SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-015030
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3838

FILED APR 27 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b

c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) D.O.A. City Hospital — Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location) 4434 Delor St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First VIRGIL Middle A. Last COMER

4. DATE OF DEATH Month Apr. Day 21 Year 1961

5. SEX Male

6. COLOR OR RACE White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 8-30-1909

9. AGE (last birthday) 51 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner-U. S. Post Office

10b. KIND OF BUSINESS OR INDUSTRY Dep't.

11. BIRTHPLACE (City and state or country) Sedalia, Mo.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME William F. Comer

13b. MOTHER'S MAIDEN NAME Lulu Alice Clegg

14. NAME OF HUSBAND OR WIFE Ruby Comer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War 2

16. SOCIAL SECURITY NO. None

17. INFORMANT Ruby Comer Address 4434 Delor St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH 5 years

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) 4200

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 11-26-56, to 4-20-61 and last saw her/him alive on April 4 1961

Death occurred at 1:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) B. J. McGinnis MD

22b. ADDRESS 16 Hampton Village Dega

22c. DATE SIGNED 4-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal(Mtr)

23b. DATE Apr. 21, 1961

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State) Warrensburg, Mo.

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S. Kingshighway Blvd.

25. DATE RECD. BY LOCAL REG. APR 21 1961

26. REGISTRAR'S SIGNATURE Earl Smith M.D.

JAN 30 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed R. W. Storrsand

Licensed Embalmer No. 4007

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.